The Psychological Approach to General Practice

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When the young physician leaves his teaching hospital to enter the field of general practice, he often finds great disparity between the clear-cut disease patterns of the hospital ward or medical out-patient clinic, and the symptom pictures of the private consulting-room. Finding himself unable to explain the latter in terms of pathology, in his bewilderment either he blames his teacher for having taught him falsely, or he explains his patient's symptoms (1) as being figments of the imagination, (2) as being expressions of such doubtful pathological entities as chronic gastritis, colitis, and rheumatism, conditions seldom seen in the autopsy room, and of whose disease-basis he is by no means clear.

Modern teaching has attempted to clear the ground by postulating two opposite mechanisms producing the same symptoms, one based on demonstrable change in bodily structure, the second based on no such visible change, either at post-mortem or subsequent microscopic examination. The former group are termed the organic disorders. The latter, rightly attributed to disorder of function rather than of structure, are said to be "functional."

It is the alarming preponderance of functional disorder over organic disease, seen in the private consulting-room, that demands a rapid mental reorientation, which the practitioner is often unable to make. But make it he must, if he is to explain satisfactorily his patient's complaints. To fail in the endeavour is to court a sense of frustration, which so often attacks the enthusiastic doctor in the middle years of general practice. It is the aim of this paper to aid that reorientation of ideas.

Most practitioners will agree that a considerable number of patients are mentally, rather than physically ill. In certain cases the origin of the illness is clearly not organic.

> "Miss A., aged 48, is the sole attendant of her aged and exacting mother. For the past eighteen years, Miss A. has had a series of complaints which first suggested lung disease, then heart disorder, and lately chronic gastritis. Repeated clinical examination, supported by hospital investigation, has been negative. In spite of her alarming symptoms, she remains in average physical health, able to carry out her household duties."

Her doctor rightly considers her a neurotic woman: for such neurosis she has adequate cause.

> "Miss B., aged 30, has consulted her doctor for shortness of breath and precordial pain on exertion. She fears heart disease, but neither her G.P. nor the cardiologist can find evidence of this. Her private doctor, however, knows that she has lately given up agreeable office life, to nurse an invalid mother who requires much lifting. Bearing in mind the history of Miss A. (cited

above), he sends Miss B. to the local psychiatric clinic, where a diagnosis of conversion hysteria is made."

It is explained to her that her symptoms have arisen out of her change over to less pleasant duties and a fear of heart disease. Such disease would unfit her for heavy nursing, but would not incapacitate her from more congenial office work, to which she could then return with a clear conscience. An unrealised psychological conflict has thus been disclosed to her. She realises that her symptoms pointed a way of escape from her mental conflict, although this escape was on an unsatisfactory plane. The explanation abolished her symptoms and enabled her to find a more satisfactory solution to her problem. She was neurotic, but her neurotic symptoms have been banished by explanation. The traditional treatment of Miss B. with bromides, reassurance, and an exhortation to "pull herself together," would certainly have failed.

Now, the art of the psychiatrist is not entirely a skilled mystery. Psychology, modern or otherwise, is based on a study of humanity, and unfolds its truths to all those who look on their patients as human problems, and not only as the possible subjects of disease. In his approach, the physician's first question must always be, "Tell me about yourself," whether he puts it as bluntly as that, or not. It is essential that the symptoms be shewn against the background of the patient's life. He is invited to describe his symptoms as fully as possible, telling his story from the beginning, and in order as nearly chronological as possible. In the first telling he should be interrupted little. Only when he has exhausted his tale, should assistance be given to elicit further facts. Questions as to home influences, sexual and business worries, incompatibilities of temperament at home or abroad, religious problems can now be put. It is of the first importance that the physician should gain the psychoneurotic patient's complete confidence; the latter should feel that his doctor's one desire is to help him. It must be made clear to the patient that the story must be told in full, nothing being held back. The listener can then separate the irrevelant from the important. A careful and complete physical examination should now be made, the patient being impressed, if possible, by his doctor's thoroughness. In view of the time taken up by this procedure, it is sometimes necessary to postpone it until the next visit. An alternative lies in gaining the patient's confidence by a careful examination at the first interview, the eliciting of the detailed history being left until later.

A mental summing-up must now be made, physical factors being weighed against mental ones. If the clinical findings are quite normal, the patient should be told so without hesitation, the absence of bodily disease being stressed. Care must be taken not to attribute symptoms which are well and fully explainable on psychological grounds, to minor variations of bodily structure or function. The softening of a heart-sound and slight increase of blood-pressure should not easily be interpreted as meaning disease. By attributing them to disease, a healthy subject can often be converted to a neurotic sufferer, whose life becomes dominated by his physician's sphygmomanometer. In making a psychological assessment, care must be taken not to accept, without serious thought, the patient's explanation

for his symptoms. Few psychological truths are at first wholly acceptable to the patient, who often prefers phantasy to truth. If the patient's theory of the origin of his disease was correct, his insight would have led to self-treatment and not brought him to our consulting-rooms. Often more is learned from the manner in which the story is told, rather than from its content. In other words, what the patient says is often less important than the way in which he says it. The purposeful but unconscious omissions often indicate what the patient is most anxious to forget. Excessive emotional stress during the recounting of certain parts of the story (called "abreaction") is often a valuable pointer to the cause of the neurosis.

An assessment of personality arises out of this. The adequacy of the personality to deal with the varied situations that arise in a person's life will be shewn by his reactions to success, disappointment, bereavement, and the shocks that punctuate the life-stream; the ability to adapt the mind to the ever-changing pattern of life, indicates the strength of the personality. The assessment shews how far the mind has strayed from normal; the adequacy and strength of the personality shew what success can be expected from any line of treatment adopted. The following case histories illustrate the points raised :—

(1) A young man in the twenties reported to the Royal Victoria Hospital, Belfast, complaining of palpitation and nervousness of five weeks duration, unrelieved by rest or sedatives. Careful physical examination shewed no evidence of organic disease. It was elicited that the symptoms began after entering a new employment, which involved work of a difficult and technical nature. Conditions of work appeared satisfactory and happy; there were no apparent home or financial problems. In childhood, he suffered under fear of failure, and subsequent humilitation; he had become proud of his ability and hated being taught by others. He confessed, under questioning, that he had been recently upset by his slowness to learn the difficult work of his new employment; in spite of assurance that such difficulties were not unusual in beginners, his pride had been hurt.

Explanation was made that his rapid heart action and palpitation arose as an emotional reaction to his difficulties, and that they were the physical expression of a fear which tempted him to fly from an unpleasant situation. He accepted the explanation and returned to work the next day, willing to be satisfied by more gradual progress. He has since remained well.

(2) A typist, aged 20, developed a sudden "heart attack" late at night. She was a frail type, obviously very agitated, and had a pulse-rate of 120. There were no other abnormal findings. After a careful physical examination, she was informed that she had no heart disease or other physical defect. On being questioned as to possible causes of anxiety, she stated that on the next day she was due to return to her office after a short holiday. She was terrified of her employer, who frequently used threatening language towards her. It was explained that her tachycardia was an expression of fear caused by her dread of returning to her employer. This fear was more real to her than the fear of physical disease, which would in itself provide an escape

from intolerable surroundings. Change of employment was advised, and when this was arranged, her "heart attacks" ceased. Here again the escape motive is obvious.

(3) An anxious, introspective woman in late middle life reported, complaining of many symptoms, prominent among which were precordial pain, palpitations, and "acid stomach." She feared cancer of the breast, and asked for assurance about her heart. Her symptoms did not suggest organic disease, and a thorough examination indicated no disease-basis for her complaints. Great relief was shewn when she was given the necessary reassurance. Further interrogation disclosed that she was widowed a few years previously, since when she had had much worry and expense. She also stated, with obvious emotion, that her son had applied for a commission in a colonial police force, and that she dreaded his leaving home. Her abreaction served as a pointer to the source of her anxieties. She was helped to realise the link between these anxieties and her present symptoms of fear. Advice was given not to "bottle up" her worries, but to face them and adapt herself to the coming loss. She accepted the explanation, and her symptoms at once disappeared.

The ætiology of the psychoneuroses is too wide a subject for consideration in a paper such as this, so many differing views having been expressed by divergent schools of thought. There is, however, no doubt that inability to adapt the life to its surroundings is an important factor in the development of a neurosis. In dealing with a patient's psychological problems, the mental background is therefore of great importance. Environment, which includes mental background, has two aspects. The first is the patient's internal environment, built up by himself and composed of his attitudes and instincts. The second factor is the external environment, provided by family and occupation. It is to this ever-changing external environment that adaptation is constantly required. When failure to adapt occurs, neurotic symptoms appear. In considering mental background, certain definite patterns emerge. There is, for instance, the patient with an inherited mental instability, whose childhood was full of fears engendered by anxious, neurotic parents, whose schooldays proved him a bad mixer and whose business career revealed a dread of responsibility. There is the dull child of degenerate physical type, whose school record was characterised by inability to learn, and who, on leaving school, finds himself unable to keep any job more than a few weeks, until at last he finds one to which his limited capacities can adapt themselves. A third and common type of environment produces what Adler calls "the pampered style," a condition of excessive indulgence of the child by unwise relatives. This produces in later years, an expectation of favours that the world does not readily confer, and an attitude of resentment when these favours are denied. In all these types, the failure to adapt the personality to life as it really is, provides the basis for the origin of the neurotic symptoms.

As has been shewn by the case histories cited above, these symptoms often arise in an effort to escape from an unpleasant situation. Unwilling or physically unable

". . . to take up arms against a sea of troubles, and by opposing, end them,"

the patient finds an escape from reality in his symptoms or even in actual disease, which will secure his release from the conflict; case (4) illustrates this point.

(4) A rent collector, aged 43, reported to the Benn Hospital complaining of anosmia; no naso-pharyngeal disease could be detected, but he was obviously of neurotic type. He had a mental background of timidity, resulting in a distaste for his type of work. He lived in a dread of rough reception from angry tenants, but could not, in face of home responsibilities, risk unemployment by seeking a change. His fears culminated in the thought, "How terrible it would be if I lost my sense of smell, and that someone should turn on the gas to kill me, while I waited for the rent." The anosmia was hysterical, and provided a way of escape from his employment, which he could accept without loss of self-respect. Psychiatric treatment consisted in explanation, convincing him by inhalation of strong ammonia that his sense of smell was not deficient, and help to solve his difficulties in a more satisfactory way.

As these examples shew, the symptoms of which a neurotic patient complains are often those associated with the physical expressions of such mental states as fear and uncertainty. Thus, shortness of breath (a phrase often used to indicate tachypnœa, palpitation, muscular tremors, and sweating), common as an expression of anxiety, dizziness, nausea, and sometimes true vertigo (the common concomitants of mountain sickness) may indicate instability. A man of strong imagination may tell us that he feels as if he lived on the edge of a volcano. If, however, this realisation of uncertainty only occurs at the deeper levels of thought, unperceived by the conscious mind, the volcano-idea will not emerge into consciousness, associated with a recognised fear. It will rather emerge in dream symbolism, as it did in the following case :—

(5) A highly imaginative and introspective child, 10 years old, emotionally unstable and slow to make friends, covered with a sophisticated manner her sensitivity to the opinions of others. Sixteen months prior to the present interview, there had been a "nervous breakdown," characterised by nervousness and insomnia, requiring relatively large doses of bromides for its control. The child's sleeplessness had now returned, but the event that had alarmed her parents most, was her coming down to them during an evening in an agitated manner, because she thought there was an volcano in eruption behind her bed. She could see its shadow, and was afraid to look round. When her confidence had been gained, she stated that she had read about a volcano three years ago, and although she had not at that time been alarmed by the story, her mind had been deeply impressed by the incident, as was shewn by the clearness with which the details had been remembered. She said that she had no worries, but later recollected, quite suddenly, that in her last term at school, she had been rather cruelly victimised by two other girls. She was due to return to school very soon. The dread of the unhappiness that might recur had been banished from her mind by an automatic act of forgetfulness, but had shewn itself, in altered guise, under the

symbolism of a volcano which might at any time overwhelm her. An understanding of her real fears led to the promise of a change of school. Her fears and troubled thoughts dispersed at once, and did not recur.

Fear often expresses itself in acute attacks, usually at night. These anxiety attacks, as described the following day, are quite naturally often diagnosed as bronchial asthma, from the bias given by the patient. The following case typifies this :—

(6) A woman of 56, who had recently nursed her daughter, aged 16, through a severe pneumonia, awoke one night in great terror, thinking that she too had developed the disease. She complained of symptoms similar to those from which her daughter had suffered. Her respiration was markedly hurried, her pulse-rate 120, but there was no fever, nor could evidence of lung disease be found. She was fully reassured about this and the origin of her symptoms in anxiety, pointed out to her. Her distress immediately lessened, her anxious look disappeared, and in a few minutes both pulse and respiration rates were normal.

The differential diagnosis of the psychoneuroses lies between organic disease producing similar symptoms and a psychosis. The latter includes the mental aberrations following petit mal epilepsy, and the periodic disturbances of mood which may alternate with grand mal attacks. A tracing of the life-path from early youth often aids the differentiation. The neurotic usually shews an instability and a failure to adapt himself from earliest years, while in the psychotic, mental development is apparently normal, until at some stage in adolescent or adult life, something happens to pervert the life force. A mind which has hitherto developed normally then begins to shew abnormalities, or to retrogress. Traits such as negativism, impulsiveness, and loss of normal affection, with detachment of emotion from action, are characteristic of schizophrenia. The neurotic's willingness to talk of his symptoms, his feeling that "things would be all right" if only his environment could be adapted to suit him, contrast strongly with the psychotic's unwillingness and the self-blame and hopelessness which he often exhibits. A mild thyrotoxisis is often diagnosed when the symptoms are due to anxiety neurosis. If it is realised that the symptoms are much alike, but that the former is much less common (being, in fact, rare in males), wrong diagnosis is unlikely to be made. The classical signs of exophthalmos, thyroid enlargement, moist skin, and large appetite (as well as other signs, such as tremor, tachycardia, and wasting, common to both anxiety neurosis and Graves' disease) should be required before a diagnosis of thyrotoxicosis is made.

A discussion of treatment is outside the scope of this article, but its basis lies in explanation of the origin of the symptoms and the establishment of a readjustment between the patient and his environment.

A word of warning should be given against exhorting the patient to use his will-power and to pull himself together. As the late Dr. T. A. Ross pointed out, the normal person exerts his will-power much less than many people suppose. In his own words: "Healthy people are not making any stupendous effort to carry

out their work. Work, if it is of any interest, is carried out with more ease than idling. If work is being done in a condition which requires constant flogging before it is accomplished, it will be found to be of very little value, and will soon better not be done at all." The will, he writes, " . . . is very like the engine starter of a motor-car, which may be used for a few seconds, but for a few seconds only, to start the engine. It is a bad practice to keep on using it, for it will only run the battery down. If I have to use it unduly, there is something wrong, which I ought to investigate. Note that I can move the car for some yards by means of the engine starter alone, but the ultimate results of doing so will be very serious. Equally nothing but damage will result from any prolonged attempt to work by the exercise of will-power." To urge the patient to pull himself together is thus essentially unsound. As Sir James Paget has expressed it: "The patient says she cannot, the nurse says that she will not, the truth is that she cannot will."

SUMMARY.

A working understanding of the origin and treatment of the simpler psychoneurotic symptoms met with in general practice, is not beyond the scope of the general physician, who has had no specialised psychological training.

This understanding requires appreciation of the origin of such symptoms and investigation of the patient's physical and mental environment, on the lines suggested above. Normal case-taking must therefore be expanded to include the assessment of environment, in its widest sense, in any case where psychological factors may be playing a prominent part.

Treatment by explanation, readaptation, and encouragement will often be followed, in simpler cases, by gratifying success. Treatment at psychiatric clinics can then be reserved for more difficult cases, or those which are not considerably benefited by the above measures.

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REVIEW

INFANT FEEDING IN GENERAL PRACTICE. By J. Vernon Braithwaite, M.D., F.R.C.P.(Lond.), with a Foreword by H. C. Cameron, M.A., M.D., F.R.C.P. Second Edition. Bristol: John Wright & Sons Ltd. Pp. 165. 7/6.

THIS is an admirable little book, based on the knowledge gained by the author first in general practice and later on the staffs of two hospitals. He is an ardent advocate of breast-feeding, and shows how real or imaginary difficulties in its promotion may so often be solved. His writing is simple and eminently readable, with many clinical case records to support this argument. In the new edition the section on vitamins has been augmented, an account of the feeding of the premature infant has been added, and a short chapter on the common deficiency diseases has been included.

This is a book which might well be presented to every young doctor, every newly-certified midwife, and every young mother.